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ABSTRACT

The four papers presented in this document address a wide range of issues in the field of gerontology. The first paper provides detailed information on the residential and mobility patterns of the elderly population of New York City. The second paper integrates general concepts about attitude development with more specific interpretations of facts about aging: it is a step toward meeting the need to study children's attitudes toward the elderly, taking into account the complexity and multi-form nature of attitude development. The third paper provides an in-depth descriptive analysis of how families cope with severe illness; the author's conception of illness in the aging family focuses attention of family growth as a potential outcome, wherein illness is seen as a developmental challenge to a family. The fourth and final paper looks at the role of the grandmother, with particular reference to religious-cultural ethnicity brought from the old world and the cultural traits acquired in the new world: a three-generational study, its treatment of ethnic change and stability offers insights into the strains that acculturation brings about in the process of adaptation to aging. (Author/CS)

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Selected Studies on Aging

Research in the Social Sciences at the Graduate School and University Center of The City University of New York

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Introduction

When the Center for Gerontological Studies of the City University of New York was initiated in July 1976, one of its early commitments was to publish work in the field of aging by the University's faculty and students. The four papers presented together here represent a first step in the fulfillment of that commitment. Drawn from recent doctoral dissertations, they address a wide range of questions, from the attitudes toward the aged by the young to inquiry about the strength under stress of universal social institutions like the family.

The order of presentation is designed to tell first who the elderly are in New York City (Perry), and how they are perceived by a segment of the community (Isaacs). Adaptation to the crisis of illness by the American family is the subject of the third paper (Speedling.) The final paper focuses on the grandparent role, and how it has both retained and changed traditional characteristics over three generations in one ethnic group during the transition from old world to new world conditions (Frank).

The volume begins, therefore, with denominator data about New York's 65 and over population. It provides the detailed pattern of the city's aged population, tracing variable age distributions by borough and health area, and also confining the analogous data for the suburban counties of the greater New York metropolitan area. The overall average for the city as a whole (the five boroughs) is 12 percent, but borough distributions show a low of 8.67% (Staten Island) and a high of 13.96% (Manhattan). The relative density of age-specific populations is even more variable by Community Planning District (CPD), and, in New York's own unique system of Health Areas (They are overlapping but not equal to the CPDs), the range is

even greater. In Manhattan, for example, the highest proportion of persons aged 65 or over, by CPD, is 21.04, while in a Health Area completely disconnected from the high CPD, the highest percentage is 28.47. Perry builds from this basic information a nicely detailed portrait of the residential and mobility patterns of the elderly population in the New York metropolitan area.

The second paper fills an important need for the integration of general concepts about attitude development with more specific perceptions of age-related facts. It is a well-known and accepted observation that people vary in many ways, and this variability appears to be noticed by the child from birth. There have been extensive studies of young children's concept and attitudes toward gender, kinship and race. However, even though it is currently asserted that the aged have a status equivalence to minority groups, there has been no study of young children during that period when attitude acquisition occurs. Although the development of concepts about people may be a necessary condition for attitude development, research on racial awareness in children has demonstrated that it is not a sufficient condition. Although investigators pay lip service to the belief that attitudes are complex and multiply determined, most theorists have focused only on a single determinant of attitudes toward the aged. There is a need for a multi-modal developmental study of young children's attitude toward the aged that this paper attempts to fulfill.

Speedling's study shifts to in-depth descriptive analysis of how families cope with the crisis of illness. His choice of heart attack victims brings aging into the focus of his analysis. Most important, he challenges the general practice of conceptualizing illness as an event that breaks into the normal life pattern, making its victims into unwitting

social deviants. Such an approach, he points out, tends to see the consequences of illness for any family in terms of (a) family disorganization, and (b) re-equilibrium (homeostasis). Another view is presented here whereby illness is seen as a developmental challenge to a family, as a normal part of the life cycle of most families. This alternative conceptualization of illness in the aging family focuses attention on growth as a potential illness outcome for family functioning following a major illness event.

The final paper of this series singles out the grandmother role, with particular reference to religio-cultural ethnicity brought from the old world and the cultural traits acquired in the new world. A three generational study, its treatment of ethnic change and ethnic stability offers insights into important strains that Americanization causes to the adaptations of aging.

Although these studies were conceived and conducted each quite separate and independent from the other, they achieve a certain unity when read together. In a substantial but modest way, their achievement is, we believe, to open a revealing window in the house of aging.

Special appreciation is here recorded to Dr. Neil G. McCluskey, Director of the CASE Center for Gerontological Studies, for his encouragement and support in seeing this project through to completion.

Anne Bloom, Ph.D.

May, 1980

RESIDENTIAL AND MOBILITY PATTERNS OF THE ELDERLY POPULATION IN THE NEW YORK METROPOLITAN AREA

Judy Perry

The population aged 65 and over is growing increasingly important in the New York area, both in terms of sheer numbers and the impact of these numbers on facilities and service needs. According to a digest of selected trends in the 31 county tri-state area.[1] (Regional Plan Association, 1975) the retirement age group, that is, those over 65, will experience a continuing expansion between 1970 and 1990, increasing by an estimated 36.8 percent, from 2,055,400 to 2,811,200. Some of this group will undoubtedly migrate out of the region, but this proportion has historically been small (less than 10 percent over the last 20 years). I will discuss the out-migration of the elderly population at the end of this paper. I want to concentrate on the overwhelming majority who remain in the New York Metropolitan Area and comprise an increasingly significant share of its total population.

Unless otherwise indicated the information which I will report has been taken from 1970 U. S. Census data (U. S. Bureau of the Census, 1973).

Where the Elderly Live

New York City. Manhattan has the highest proportion of residents over the age of 65 of any of the boroughs of New York City -- 13.96 percent. Queens has 12.44 percent of its population in the 65 and over age interval, followed by the Bronx, with 11.61 percent, Brooklyn, with 11.10 percent, and Staten Island, with 8.67 percent. The average for the city as a whole is 12 percent. As with any population sub-group the elderly are not evenly

distributed within the boroughs. The next sections will describe the population distribution of persons aged 65 or over within the five counties of New York City, by Community Planning Districts (CPDs) and health areas. (Health areas are aggregates of census tracts generally ranging in population from 10,000 to 40,000; Planning Districts are much larger, usually containing between 100,000 and 200,000 residents.)

Manhattan. The highest proportion of persons aged 65 and over, 21.04 percent, is found in Community Planning District 5. District 5 is located between 14th Street and 59th Street, and between Lexington Avenue and the Avenue of the Americas south of 26th Street, and between Lexington Avenue and Eighth Avenue north of 26th Street, where the eastern boundary of the district is Madison Avenue. This 21 percent, however, represents only 6,621 people, as this is not a densely populated residential neighborhood. The largest number of people over 65 years of age in any one planning district in Manhattan is 33,797, in CPD 8, located between 59th and 96th Streets east of Fifth Avenue, including Yorkville, Lenox Hill and what was, in 1970, Welfare Island (now Roosevelt Island). The institutional population of Roosevelt Hospital and other facilities in the district undoubtedly contributes to the large number of elderly living there. The 33,797 people 65 and over represent 16.88 percent of the total population of the district. CPD 7, west of Central Park from 60th Street to 110th Street contains 33,313 persons aged 65 and over, 15.69 percent of its total population. CPD 12, which encompasses the Washington Heights and Inwood communities at the tip of Manhattan north of 155th Street contains 32,432 persons over age 65, representing 17.29 percent of the total population of the district.

In terms of both numbers and proportion of the total population the Community Planning Districts with the largest elderly populations are overwhelmingly white. This may be changing, however, as the older residents of these neighborhoods die and are replaced by expanding populations of younger non-whites from neighboring areas.

Table 1 shows the ten health areas in Manhattan with the highest proportion of residents aged 65 and over. Each of the ten is at least partially located in the planning districts mentioned above.

Queens. While Queens ranks second overall in proportion of its population aged 65 and over, no single Community Planning District contains a higher percentage than the 16.94 percent, for District 6, which encompasses Forest Hills and Rego Park. This 16.94 percent represents 20,165 people. The next highest percentage is 16.39 percent, for CPD 5, which borders District 6 on the west and includes the communities of Ridgewood, Glendale, and Middle Village. There are 20,523 people aged 65 and over in the district.

Three Community Planning Districts have more elderly than the two already mentioned, though they represent a smaller proportion of the total population. CPD 1, including Astoria and Long Island City contains 26,703 people aged 65 and over; CPD 7, including Flushing, College Point, Whitestone, and part of Bayside has 23,278 elderly residents; and CPD 12, including Jamaica, St. Albans, and Springfield Gardens has 22,897 residents 65 years of age and over

With the exception of District 12, all these communities contain populations which are overwhelmingly white. In CPD 12 the population is approximately 65 percent non-white; however the elderly population represents only 9.97 percent of the total population, which is among the smaller proportions in the borough of Queens.

Table 2 lists the ten health areas in Queens with the highest proportion of residents aged 65 and over. The pattern that emerges here is different than that of Manhattan. Several health areas with large proportions of elderly residents are in Community Planning Districts with neither large numbers nor large proportions of residents over 65. Health area 37, with 7,329 elderly residents, together with health area 39, with 7,966 elderly residents are located in CPD 14, which encompasses the Rockaway peninsula. CPD 3, in which health area 10.11 is located consists of Jackson Heights, North Corona, and East Elmhurst; and CPD 2, in which health areas 8 and 9.10 are found, includes Maspeth, Sunnyside, and Woodside.

Table 1

Health Areas With Highest Proportion of Elderly Residents -- Manhattan

Health Area	% 65 & over	# 65 & over	CPD(s) in which located
2.22	28.47	4772	12
48	26.13	3665	5;8;6
41	23.36	5770	8
46	23.16	2740	4
40	21.40	4706	7
7.10	19.76	1687	9;12
55	19.66	1981	4
52	19.45	4600	4;5;6
2.21	19.11	4235	12
3	18.87	3687	12

Table 2

Health Areas With Highest Proportion of Elderly Residents -- Queens

Health Area	% 65 & over	# 65 & over	CPD(s) in which located
19.20	24.11	7830	6.9
10.11	21.31	4541	3
37	20.27	7329	14
23	19.28	3602	5
9.10	18.41	3571	2
22	18.39	3427	5
8	17.68	4049	2
24	17.53	4004	5
26	17.46	4631	9
28.10	16.97	4644	12;8

The Bronx. As of 1970, Community Planning District 7 in the Bronx, including the communities of Mosholu, Bedford Park, Kingsbridge Heights, and Norwood, had the highest proportion of elderly residents of any CPD in New York City, 21.29 percent. The same district also contains the largest number of people aged 65 and over in the borough, 28,138. The second highest proportion of those aged 65 and over, 18.26 percent, is found in CPD 11, which includes the communities of Pelham Parkway, Morris Park, Bronxdale, Van Nest, and Westchester. The second highest number of elderly, 20,126, are located in CPD 5, which includes the Concourse, Tremont, University Heights, Morris Heights, and Fordham Heights. The third largest number, 19,718, are found in CPD 4, which encompasses the Concourse, Highbridge, and Claremont communities.

Community Planning Districts 7 and 11 have the highest percentage of whites in the population, 97.6 percent and 96.6 percent, respectively. Districts 4 and 5 have white majorities as well, but not as overwhelming. The figures are 66.3 percent and 77.2 percent,respectively.

Table 3 lists the ten Bronx health areas with the highest proportion of elderly residents in the population. In addition to the planning districts already discussed Districts 9, 13, and 14 are represented. CPD 9 is in the Parkchester and West Farms area. Districts 13 and 14 are the northernmost in the borough, with 14 including Riverdale, Kingsbridge, and Spuyten Duyvil, and 13 including Williamsbridge, Eastchester, and Woodlawn. These areas are also overwhelmingly white.

Brooklyn. Community Planning District 14, in the Flatbush, Midwood, and Kings Highway area of Brooklyn has the highest proportion of residents aged 65 and over, 18.54 percent. There are 36,701 senior citizens in the district, which is the largest number of persons aged 65 and over in any

single CPD, not just in Brooklyn, but anywhere in New York City. Planning District 10, in the Bay Ridge and Fort Hamilton area contains the second highest proportion of elderly residents in Brooklyn, 17.34 percent of the total population. With 17.18 percent of its population aged 65 and over CPD 15 ranks third in the borough. It is located in the Sheepshead Bay, Brighton Beach, and Manhattan Beach area of southern Brooklyn.

In terms of raw numbers CPD 12, with 27,877 residents aged 65 and over, ranks second after CPD 14. It includes the Borough Park, Kensington, Bay Parkway, and Ocean Parkway communities. The aforementioned CPD 15 has 24,278 elderly residents, which ranks third, followed by CPD 6, with 21,775, and CPD 10, with 21,734. With over 200,000 residents, CPD 6 is one of the largest in Brooklyn. It includes South Brooklyn, Park Slope, Brooklyn Heights, Cobble Hill, Boerum Hill, Carroll Gardens, Red Hook, Gowanus, and Windsor Terrace.

It is noteworthy that such predominantly black and Hispanic communities as Bedford-Stuyvesant, Ocean Hill, Brownsville, East New York, Bushwick, and Williamsburg are not among those with large proportions of elderly residents. As was the case in Manhattan, the older population in Brooklyn resides in predominantly white neighborhoods.

Table 4 describes the ten health areas in Brooklyn with the highest percentages of their populations aged 65 and over. Most of the health areas are at least partially in those CPDs discussed above. The one exception is health area 90.20, which is located in Coney Island, which in turn is in CPD 13.

Staten Island. Staten Island contains only four Community Planning Districts and ten health areas. The highest proportion of elderly residents is found in CPD 2, 11.08 percent. This represents only 8,905 people, but is

Table 3

Health Areas With Highest Proportion of Elderly Residents -- Bronx

Health Area	% 65 & over	# 65 & over	CPD(s) in which located
13.10	23.37	9234	9
4.10	22.40	6415	7
9	22.14	6851	7;5
4.20	21.81	6156	7
12.10	21.42	5345	11
3.20	21.23	5661	7;14
16	19.73	5476	5
8.10	19.68	7043	11;13
23.20	19.25	2890	4
5.10	17.70	3589	13

Table 4

Health Areas With Highest Proportion of Elderly Residents -- Brooklyn

Health Area	% 65 & over	# 65 & over	CPD(s) in which located
91.10	3582	6002	15
91.20	37.97	4282	15
53.20	21.80	6820	14;8
72.10	21.15	8133	14
73.20	20.56	4881	14
73.10	20.10	5339	14
78.10	20.04	5628	10
90.20	19.13	5912	13
79.10	18.72	2706	10
72.20	18.41	3261	14;12;18

the largest total of people over 65 of any district in the borough. In the northeast part of Staten Island, bordering on the Kill Van Kull and the Narrows, CPD 2 includes the communities of Clifton, Fox Hills, Livingston, New Brighton, Rosebank, Stapleton, and Tompkinsville. The health areas with the highest proportion of elderly residents are 4, with 13.15 percent; 3, with 11.19 percent; and 2, with 10.77 percent. All of health area 4 and 90 percent of health area 3 are in the aforementioned CPD 2. Specifically, health area 4 is in New Brighton and health area 3 is in West New Brighton. Health area 2 is in the Port Richmond/Mariner's Harbor area of CPD 1, in northwestern Staten Island.

The elderly population on Staten Island is overwhelmingly white, as is the general population of the borough.

The Suburbs

By and large there are fewer elderly people in the suburban counties of the New York Metropolitan Area than in the central city, but that is not to say that there are no areas with significant proportions of persons aged 65 or over.

Nassau. Although persons aged 65 and over are found throughout most of the county, the City of Long Beach, with 6,492 persons aged 65 and over led all other cities, villages, and unincorporated places in Nassau County. Thirty-six Nassau communities listed more than 1000 senior citizens among their residents, according to the 1970 census.

The census tracts with the largest population of elderly residents are generally concentrated in Long Beach, and in the older villages of west and southwest Nassau; including Great Neck Plaza, in North Hempstead Town; Rockville Centre, in Hempstead Town; and Oyster Bay. Eighty out of

225 Nassau tracts reported 500 or more elderly residents, and eight tracts reported 1000 or more. Of the ten tracts with the greatest number of persons aged 65 and over, all but one contain a considerable number of multiple family dwellings, and the remaining tract (in Hempstead) is the site of a home for the aged.

Nearly all Nassau communities counted more elderly persons in 1970 than in 1960, with 126 out of 142 census reporting areas recording increases. Increments ranged from a gain of one person (in South Floral Park) to a gain of 3,812 people in the City of Long Beach, an increase of 121.8 percent. In addition to Long Beach, the Village of Hempstead gained 1,103 elderly residents, and another 19 communities recorded increases of between 500 and 1000 persons aged 65 and over. These 21 communities together accounted for a gain of 17,561 senior citizens, 56 percent of the total county-wide growth for this age group for the period between the 1960 and 1970 censuses. As is consistent with the data reported above, 14 of the 21 communities that experienced the largest rise in the number of elderly residents are in the Town of Hempstead (including Franklin Square, Lynbrook, Uniondale, and Valley Stream), and 3 each are in the towns of North Hempstead and Oyster Bay. The City of Long Beach is the other.

Losses in the 65 years and over category were extremely small during the intercensal period, ranging from a decrease of one on the Off Shore Islands to a decrease of 136 in Bellerose Terrace. In six of the ten communities reporting fewer elderly residents in 1970 than in 1960 reductions involved 20 persons or less.

Increases in the 65 years and over component provided a significant part of the total population growth in many Nassau communities where

additions to the oldest group often offset losses in one or more of the younger age groups. These areas have the type of housing facilities, services, and amenities that tend to attract or retain older residents. In other cases gains in the older segment of the population were a result of rapid overall growth affecting all components of the population.

Suffolk. Forty- seven Suffolk communities reported more than 100 senior citizens among their residents, though eight Nassau communities have more people 65 and over than does the top ranking area in Suffolk. The top two areas in the county are both institutional facilities -- Central Islip State Hospital, with 2,835 elderly persons and Kings Park State Hospital, with 2,176. The highest ranking non-institutional community is North Babylon, with 2,140 residents aged 65 and over.

When institutional areas are excluded from consideration, the census tracts with the greatest number of elderly inhabitants are found throughout the East End towns and in the older incorporated villages and hamlets such as Amityville, Patchogue, and Bay Shore. Concentrations of senior citizens are also common in such areas as Mastic Beach, Sound Beach, Rocky Point, and Lake Ronkonkoma, where winterized seasonal bungalows and cabins provide low cost housing for people with limited incomes. Fifty out of 202 census tracts in Suffolk counted 500 or more senior citizens, eight tracts counted 1000 or more. Again excluding the institutional tracts, the tracts with the most inhabitants aged 65 and over are in the towns of Southampton, Southold, Riverhead, and in the northeast part of Brookhaven, adjacent to the Riverhead -- Brookhaven boundary. Of the tracts with the highest proportion of elderly residents two are in Southhampton, two in Southold, and one each in Shelter Island, East Hampton,

and Brookhaven. The Brookhaven tract is in the southeast sector of the town, in the part of seasonal - part year-round community of Mastic Beach.

As was the case for Nassau County, nearly all Suffolk communities had more elderly residents in 1970 than in 1960. One hundred eighty-two census reporting areas recorded increases and 15 recorded decreases. The gains were smaller than those in Nassau, with increments ranging in size from a three person addition to the elderly population in the Village of Poquott to a 909 person addition in North Babylon. Only six Suffolk communities -- four in the Town of Babylon (North Babylon, Deer Park, Lindenhurst, and West Babylon) and two in the Town of Islip (Brentwood and Central Islip) -- recorded gains of 500 or more persons. The most signigicant decreases were in the count of elderly patients at Pilgrim State and Central Islip State Hospitals, a drop of 1,271 persons between 1960 and 1970.

Unlike most Nassau communities,where the rate of growth of the oldest component exceeded that of the population as a whole, most Suffolk communities experienced slower growth in the senior citizen group than in the population as a whole. In most tracts the rise in the number of elderly people is attributable primarily to the rapid growth in all age groups.

Westchester. Of the four suburban counties in the New York Standard Metropolitan Statistical Area (SMSA) Westchester has by far the largest proportion of residents aged 65 and over in its population, 10.6 percent (94,931 of a total population in the county of 894,104).

The community with the largest number of elderly residents is Yonkers, with 24,066 inhabitants aged 65 and over. This number represents 11.78 percent of that city's total population. Yonkers is followed by Mount Vernon, with 9,056 (12.44 percent of the total); New Rochelle, with 9,053

(12.91 percent); White Plains, with 6,621 (13.21 percent); and Port Chester, with 2,974 (11.53 percent of the total population).

There are 43,161 people aged 65 and over in the balance of Westchester County, which is 9.27 percent of the total population. The proportions in individual communities range from a low of 5.13 percent in Yorktown (1,439 persons) to a high of 16.39 percent in Bronxville (1,094 persons). The numbers range from a low of 236 elderly inhabitants in Buchanon (11.18 percent of the total population) to a high of 2,942 in Greenburgh (7.26 percent of the total population).

Rockland. At 7.0 percent of the total population the proportion of elderly residents in Rockland County is the lowest in the New York SMSA. There are 16,087 persons aged 65 and over in Rockland, according to the 1970 census. This represents an increase of 4,780 persons from 1960, but a decrease from 8 percent to 7 percent during the intercensal period.

The data for towns and villages in Rockland is presented for those aged 60 and over. The 23,144 so-called retirement age people represent 10 percent of the total population of the county. There are 4,519 people aged 60 and over in Clarkstown, 3,377 in Orangetown and 3,361 in Ramapo representing 8 percent, 9 percent, and 7 percent of the totals, respectively. Excluding the Rockland State Hospital, which in 1970 had a population of which 36 percent were aged 60 or over; the largest proportions of retirement age inhabitants are found in the villages of Nyack, South Nyack, and Upper Nyack (16 percent in each instance), followed by Haverstraw, with 14 percent, and 13 percent in Piermont.

Mobility of the Elderly

The preceding section described the areas of the New York Metropolitan Region with the greatest number and proportion of elderly residents in their

population. The following section will deal with the stability or instability of the older population, as measured by their mobility, or lack thereof. This description of mobility patterns is based on an analysis of 1970 census data. The specific item which is my principal source of information asked for the respondents' place of residence in 1965, with the answers categorized as follows: (1) same house; (2) different house, same county; (3) different county, same state; (4) different state (further divided into four regions -- the northeast, north central, south, and west); (5) abroad; and (6) moved, residence in 1965 not reported. The total population over age 5 is divided into five year age intervals, from 5 to 9 to 80 to 84, with those over 85 grouped together. This division provides more detail than does the grouping together of all people over 65. The information is also reported not only for the total population, but also separately for whites, blacks, and Puerto Ricans. These categories are not mutually exclusive in that Puerto Ricans are counted as either black or white.

Within the Region

In New York City as a whole, and in each borough taken separately, the vast majority of residents over 65 were living in the same house in 1970 as in 1965. As shown in Table 5, the highest percentage of non-movers is found for those in the 70-74 age group, except for Manhattan and Queens. In those two counties the highest percentage of non-movers fall into the 75-79 year age interval.

The same general pattern as exists for the total population holds for the white population. It also holds for the much smaller black population, though the percentages are slightly lower. There are some exceptions, however. The Queens pattern differs slightly in that the percentage of black

Table 5

and % of Persons Aged 65 & Over Living in Same House in 1970 as in 1965, for New York City and Boroughs

	65-69	70-74	75-79	80-84	85 & over
New York City					
#	274,759	214,397	136,427	71,666	41,860
%	77.55	78.60	78.45	76.39	72.06
Bronx					
#	48,800	38,164	23,997	13,310	6,972
%	76.42	77.75	76.59	74.07	67.07
Brooklyn					
#	84,824	66,551	40,550	21,760	12,755
%	77.66	79.10	78.31	77.34	73.07
Manhattan					
#	60,929	49,042	32,121	16,461	10,493
%	77.82	79.24	80.21	77.05	72.99
Queens					
#	73,553	55,325	36,108	18,120	10,442
%	78.30	78.35	78.96	77.07	74.60
Staten Island					
#	6,653	5,315	3,651	2,015	1,218
%	74.24	75.32	72.82	70.90	63.94

non movers drops off more sharply, from a high of 79.5 percent (for 75-79 year olds) to 64.6 percent (for those aged 85 and over). The number of older blacks in Staten Island is too small to allow comparison with the overall city pattern of movement.

The small amount of mobility among the elderly has a bearing on neighborhood stability in general. Unless younger people continue to move into communities where the older residents remain the community is likely to decline, since older residents do not replace themselves. If there is population turnover involving all age groups, however, the presence of older residents could exert a stabilizing influence on the community.

The most plausible explanation for the stability of the elderly population is that they are reluctant to leave rent controlled apartments or homes where they have lived for long periods of time, and the attachments to people and places which go along with them. The slight increase in mobility after age 75 undoubtedly reflects the movement of older citizens into nursing homes, apartment complexes designed for older residents, or their children's households, when they are no longer able to maintain households of their own.

After non-movers, the next highest percentage of persons aged 65 and over fall into the category of movers to a different house in the same county. For the city as a whole, 11.18 percent of the 65-69 year olds, 10.55 percent of the 70-74 year olds, 10.59 percent of the 75-79 year olds, 11.08 percent of the 80-84 year olds, and 12.03 percent of those aged 85 and over were within-county movers. Brooklyn was the borough with the most within-county movers, followed by Staten Island and the Bronx, with Queens and Manhattan having the fewest. The Brooklyn figures are in the 13.5 to

14.5 percent range; for the Bronx they range from 11 to 15 percent; for Staten Island, they range from about 10 to 13.5 percent; for Queens, from 8.5 to 10.5 percent; and for Manhattan, from about 8 to 9 percent.

The third largest proportion of elderly residents are those who moved from one county to another county within New York State. Included here are movers within the city, movers from the suburbs to the city, and movers from upstate communities. For all of New York City, 5.42 percent of 65-69 year olds, 4.95 percent of 70-74 year olds, 4.93 percent of 75-79 year olds, 5.30 percent of 80-84 year olds, and 6.18 percent of those aged 85 and over were migrants from other counties in the state. There is greater disparity between the various boroughs in this category of mobility than was the case in those previously discussed. This may be in part because of the smaller numbers involved. For example, Staten Island has the largest proportion of migrants from elsewhere in the state, but the fewest in number. There are 876 people aged 65-69 who moved to Staten Island from another county, which represents 9.8 percent of the 65-69 year olds; 574 70-74 year olds (8.1 percent of the total) were in-migrants from other counties; 402 75-79 year olds (8.0 percent); 263 80-84 year olds (9.2 percent); and 269 people 85 and over (14.1 percent) fall into this category. Queens ranks second among the boroughs with percentages of in-migrants ranging from 7.5 to 8.3 percent. The Bronx is next, with from 5.5 to 8.7 percent of its elderly residents moving in from elsewhere in New York State; followed by Manhattan, with from 4 to 5.8 percent in-migrants from other New York counties. The smallest proportion of elderly in-migrants from elsewhere in the state reside in Brooklyn, where the percentages range from 1.9 percent (for 70-74 year olds) to 2.6 percent (for those 85 years old and over).

Table 6

Mobility Status of the Total and Black Population
Aged 65 & Over in the New York SMSA

CENTRAL CITY	Same House	Mover w/in c.c.	From bal. SMSA
# total Males 65+	306,614	61,290	1,565
% total Males 65+	77.87	15.56	.40
# total Females 65+	432,495	87,564	2,521
% total Females 65+	77.36	15.66	.45
# black Males 65+	27,217	5,740	73
% black Males 65+	73.89	15.58	.20
# black Females 65+	40,431	9,241	141
% black Females 65+	72.62	16.60	.25

BALANCE OF SMSA	Same House	Mover w/in bal.of SMSA	Mover from c.c.
# total Males 65+	93,084	13,801	9,589
% total Males 65+	74.19	11.00	7.64
#total Females 65+	129,764	23,243	15,314
% total Females 65+	70.36	12.60	8.30
# black Males 65+	3,571	626	233
% black Males 65+	70.23	12.31	4.58
# black Females 65+	4,812	1,151	331
% black Females 65+	65.97	15.78	4.54

From what is known about mobility patterns in general it is safe to assume that most of the movement from other counties in the state is taking place within the five counties of New York City, since movement from the suburbs to the city is less common than out-migration to the suburbs. However, some older residents may be giving up large suburban homes they no longer need and moving back into the city.

Additional census data supports this hypothesis, by describing separately the mobility patterns of central city residents and those of residents in the balance of the New York SMSA. Fewer than 1 percent of the residents over the age of 65 in New York City in 1970 lived in the four suburban counties in 1965, compared with more than 15 percent who lived in one of the other four New York City counties. In the suburbs, approximately 8 percent of the population aged 65 and over were living in the central city in 1965, about 12 percent moved within the suburban counties. As Table 6 shows, there are more females aged 65 and over than males in both the city and the suburbs, and the women exhibit more mobility. This table also shows that there are comparatively few older blacks in the balance of the SMSA, and they exhibit less out-migration from the central city than do whites.

The next step in this analysis focuses on migration between the counties of New York City. Additional unpublished census data specifies the county of residence in 1965 of all in-migrants to each of the five boroughs of New York City for the 1965 to 1970 period, by age. More than half of the over 65 year old in-migrants from other New York City counties to the Bronx came from Manhattan (52 percent). Brooklyn drew most of its older in-migrants from Manhattan as well (35 percent), followed by Queens (23 percent) and the Bronx (18 percent). Manhattan drew 22 percent of its

elderly in-migrants from Brooklyn and another 22 percent from the Bronx. The bulk of the in-migrants aged 65 and over from other New York City counties to Queens came from Brooklyn (47 percent), with another 21 percent each from the Bronx and Manhattan. Finally, Staten Island drew 58 percent of its older-in migrants from other counties from Brooklyn. The pattern for elderly whites is similar to that of the total population since whites make up the majority of the total population over age 65. The pattern for the older black population is somewhat different. The percentage of the in-migrants originating from Manhattan is generally higher -- 60 percent of those living in the Bronx, 42 percent of those living in Brooklyn, 30 percent of those in Queens, and 30 percent of those in Staten Island. There are generally fewer migrants from Brooklyn and Queens among blacks aged 65 and over.

Outside the Region

Returning to the analysis of the census item described at the beginning of the previous section, in-migrants from other states and abroad make up only a tiny percentage of the total population aged 65 and over in New York City and each of its constituent counties. For the city as a whole, the percentages of immigrants ranges from .67 percent (for those aged 80-84) to 1.04 percent (of those aged 65-69). The percentages are slightly higher for Manhattan (from .80 to 1.16 percent) and Queens (from .82 to 1.19 percent) than for the city as a whole, and slightly lower for the Bronx, Brooklyn, and Staten Island. Of the four regions into which the "different state" category was divided, the biggest proportion of older in-migrants come from the northeast, followed by the south. The smallest proportion come from the west. However, even the northeast region accounted for less than .4 percent of the total in-migrants between 1965

and 1970 for each of the age intervals of the over 65 component of the population.

Among the elderly, out-migrants from the New York Metropolitan Area outnumber in-migrants by a wide margin, as Table 7 indicates.

Table 7

Number of Elderly Migrants to & From New York SMSA, 1965-70

	In-migrants	Out-migrants
Total Males 65+	5,109	39,805
Total Females 65+	9,220	48,838
Black Males 65+	428	892
Black Females 65+	1,024	1,513

Counties in the immediate surrounding area drew most of the out-migrants from the New York SMSA between 1965 and 1970, regardless of age. Bergen and Passaic Counties in New Jersey (the Paterson-Clifton-Passaic SMSA), which drew 60,207 movers from New York top the list; followed by the upstate counties of Columbia, Dutchess, Greene, Orange, Putnam, Sullivan, and Ulster, which collectively attracted 58,544 movers from the New York SMSA; and by the New Jersey counties of Hunterdon, Middlesex, Monmouth, Somerset, and Sussex, which drew 48,731 out-migrants.

Three Florida SMSAs rank among the fifteen principal destinations of out-migrants from the New York SMSA -- Miami, which ranks fourth, with 47,149 movers from New York; Fort Lauderdale-Hollywood, which ranks eighth, with 27,041 movers from New York; and Tampa-Saint Petersburg, which ranks

fourteenth, with 12,797 movers from New York. It is my hypothesis that the majority of the migrants from New York to Florida are older persons, which would account for the fact that while 86,987 people moved from New York to these cities, only 10,253 people migrated to New York from these Florida SMSAs. Evidence to support this hypothesis again comes from census data. For each of the three Florida SMSAs, most of the movers in the category "movers from another SMSA", into which New York falls, are over 55 years of age, when the central cities and balance are added to arrive at a total SMSA figure. The over 65 age group contains the single largest number of in-migrants from other SMSAs of any age group. It contains 28,190 of the total 161,207 in-migrants from another SMSA to the Miami SMSA; 31,262 of the total 156,033 in-migrants from another SMSA to the Ft. Lauderdale-Hollywood SMSA; and 33,006 of the total 158,275 in-migrants, but it is safe to assume that they do comprise a significant portion of the in-migrants in the category "movers from another SMSA", just as it is safe to assume that a good many, if not most, of the 86,987 out-migrants from New York to these Florida communities are aged 65 and over.

Still further support for the contention that older persons are the principal out-migrants from New York who wind up in Florida is supplied by the following data for New York State: 62,115 out-migrants from the state aged 65 and over moved to the southern region. That is more than three-fourths of the total of 81,080 out-migrants to non-contiguous states.

Notes

[1] The area includes New York City, Nassau, Suffolk, Rockland, Westchester, Putnam, Orange, Dutchess, Ulster and Sullivan counties, in New York; Fairfield, New Haven and Litchfield Counties in Connecticut; Bergen, Essex, Union, Passaic, Morris, Hudson, Somerset, Middlesex, Monmouth, Ocean, Mercer, Hunterdon, Warren and Sussex Counties in New Jersey.

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THE DEVELOPMENT OF CHILDREN'S ATTITUDES TOWARD THE AGED

Leora W. Isaacs and David Bearison

One of the most significant and deep-rooted problems facing the elderly today is negative social attitudes toward them. It constitutes a form of prejudice similar to racism and sexism in that negative attributes are attributed to old people to the exclusion of their individual abilities and achievements. The debilitating effects of agist prejudice are just beginning to be understood. Findings indicate that it not only contributes to a negative self-image but also is often responsible for severe depression and death. Furthermore, the negative views toward aging among the aged reinforce the negative views that younger people have of the aged, thus breeding a vicious cycle of age prejudice.

While aging affords elevated social status to people in some countries, in the United States and other industrialized nations the elderly suffer from a loss of status, reduction in personal contacts, and social climate which views aging with fear and distaste (Bringman and Reider, 1968). Findings have shown that important features of the social environment to which the elderly must adapt involve the extent to which others invite or shun them, include or ignore them, support or attack them, reward or negatively sanction them (McTavish, 1971). Although it is estimated that by the year 2000 almost a quarter of the population will be 65 or older, the crucial people in the aging problem are not just the elderly, but younger age groups who determine the social status of the older person and who are, themselves, negatively socialized for their future old-age roles (Rosow, 1962). It is among these younger age groups that this cycle of prejudice can be broken.

Self-image and attitudes toward aging among the elderly

Social psychological research has shown that the negative expectations of others are incorporated into one's self-image (Mead, 1934; Rem, 1965; Kelly, 1967), and that acute negative self-concepts or feelings of incompetence lead to anxiety, and that those which are chronic are severely incapacitating (Lefcourt, 1973; Seligman, 1975). There is substantial evidence that old people in the United States have both a negative self-image and negative view of aging.

Mason (1954) compared the self-images of a community of institutionalized, middle-class adults over 55 to groups of lower-class young adults. He found that the old people had more negative views of themselves than the young people had of themselves. Wallach (1961) found that young adults rated the concept of "myself" and "ideal person" more favorably than did older people, demonstrating the decline in positive self-regard in old age. Surveys have also indicated that elderly respondents tend to view old age in a negative way (Riegel and Riegel, 1960).

An indication of the status of a group is the willingness of individuals to classify themselves as members. Tuckman and Lorge (1954) asked people between the ages of 20 and over 80 years to classify themselves as young, middle-aged or old. Only among people over 80 did a majority classify themselves as old. Similarly, Busse, Jeffers and Obrist (1959) studied retirees and volunteers from Golden Age clubs who were over 60. He found that the older a person was, the more likely he was to think of himself as belonging to an old age group and being in poor health. To think of oneself as old does not necessarily reflect a negative self-image because it can be, after all, an accurate perception of oneself (Bennett and Eckman, 1973). However, several investigators (Jyrkila, 1960; Busse, 1968) found that old people who view themselves as old tend to be more

maladjusted or sicker than those who view themselves as young. While thinking of oneself as old may not necessarily denote a negative self-image, denying that one is old suggests negative attitudes toward aging.

Recent findings have indicated that many of the negative features that people tend to associate with aging and the aged (e.g., failing health, loneliness, resistance to change and loss of control of significant events in one's life) are not inevitable consequences of the aging process. Leaf (1973) examined three remote villages in which people often live to the age of 100 or more in good physical and mental health, and found that along with genetic factors, physical activity and sense of usefulness and purpose in life were highly correlated with longevity. This relationship has also been suggested by Butler (1967). Edwards and Wine (1963) have shown that the increased caution which correlates with aging (Botwinick, 1966; Kogan and Wallach, 1961; Krugman, 1959) tends to disappear if nonverbal intelligence effects are partialled out. Actual pathology does not seem to be related as much to aging, per se, as to either diminished development earlier in life (Lowenthal, 1968) or failure to adjust adequately to psychological and sociological changes that accompany aging (Heilbrun and Lair, 1964). Thus, the ability to sustain a sense of high self-regard and purpose in life is probably more influenced by societal factors than by the actual process of aging.

The immediate social environment in which old people find themselves effects their self-esteem and attitudes toward aging. For example, institutionalized old people have more negative views toward aging than matched subjects outside of institutions (Tuckman and Lorge, 1952; Mason, 1954). For many there is a perceived loss of control accompanied by feelings of depression and helplessness.

There is considerable evidence documenting the debilitating effects of perceived loss of control. In one study (Pervin, 1963) it was found that subjects were more anxious in situations when an experimenter controlled the application of shock than when they controlled the application of shock themselves, although the same amount of shock was administered in both conditions. In another it was found that by inducing the perception of control over stress in hospital patients, subjects requested fewer pain relievers and sedatives and were rated by nurses as evidencing less anxiety (Langer, Janis and Wolfer, 1974). Others have reported that the perception of control over an impending event reduces the aversiveness of that event (Bowers, 1968; Glass, Singer and Friedman, 1969; Kanfer and Seidner, 1973).

According to Seligman (Seligman and Maier, 1967; Seligman, Maier and Geer, 1968; Seligman, 1975) the belief that one cannot influence the production of positive outcomes in life is a form of learned helplessness that is at the root of reactive depression. The depressed person is slow to initiate responses to overcome his or her helplessness because of the perception that any response is futile. According to Lefcourt (1973), "a sense of control, the illusion that one can exercise personal choice has a definite and positive role in sustaining life."

Evidence linking the need for people to maintain a sense of control in their lives for their health and survival has been quite dramatic. McMahon and Rhudick (1964) found a relationship between depression and death and Schmale (Adamson and Schmale, 1965; Schmale, 1958; Schmale and Iker, 1966), in a series of retrospective studies, found that ulcerative colitis, leukemia, cervical cancer, and heart disease were associated with feelings of helplessness and loss of hope experiences by the patient prior to the onset of the disease. The most dramatic evidence in regard to old

people, in particular, comes from a study by Ferrari (1962) in which it was found that among seventeen people who claimed to have had no choice in choosing a place of residence but to move to a particular nursing home, eight died within four weeks of residence and a total of sixteen within ten weeks of residence. By comparison, among the residents who claimed that they had the freedom to choose other alternative, only one died during that initial period. In each case, the deaths of these residents were without any warning.

There is also evidence that the negative effects of helplessness associated with aging can be reversed. Langer and Rodin (1975) conducted a study of nursing home residents who had been randomly assigned to live on one of the two floors of the home according to room availability upon arrival. Both floors had welfare, medicaid and private residents. Residents on one floor were designated as the "responsibility-induced group" and residents on the other floor, the "staff-supported group." The responsibility-induced group was encouraged to assert their self-control concerning living conditions while no direct encouragement was offered to the staff-supported group. It was found that residents in the responsibility-induced group were happier and more active at the close of the experimental phase than prior to it, while there were no changes in the staff-supported group. Nurses also rated the responsibility-induced group as becoming more alert, active, cheerful, interested in daily events and less dependent. Thus, the self perceptions of the elderly can be modified to lead to a greater sense of well-being.

Attitudes toward aging and the aged among adults

It is not only the elderly who view old age as a period of loss and

helplessness; adults also have negative attitudes toward aging and the aged. The most extensive research on attitudes toward aging and the aged was conducted by Lorge and his associates (Tuckman and Lorge, 1953; Lorge, Tuckman and Abrams, 1954; Arnhoff and Lorge, 1960). They found that old people are expected to play a decreasingly active role in life and that these expectations are strongly associated with stereotyped ideas concerning old age. They found that both younger and older adults viewed old age as a period of economic insecurity, poor health, loneliness, resistance to change or rigidity, failing physical health, and loss of mental prowess. The existence of these stereotypes regarding old age has been confirmed in other studies (Golde and Kogan, 1959; Kogan, 1961; Zola, 1962; Rosencranz and McNevin, 1969; Seltzer and Atchley, 1971; Naus, 1973; Weinberger and Millham, 1975; and Collette-Pratt, 1976).

Although increased social contact with aged people in our culture might facilitate the development of positive affect toward them, unless their status is elevated or they are seen to function in highly valued roles, elderly people will continue to be devalued by adults in our society. In most cases, the depressed status of the aged is associated with their perceived lack of authority, their ineffectiveness in controlling events in their lives and their lack of independence. Collette-Pratt (1976) found that college students as well as middle-aged adults devalued old age, citing such factors as loss of personal productivity, achievement, and independence. Negative attitudes concerning death and declining health were the most significant predictors of old age devaluation.

Several investigators have argued that prejudicial attitudes toward others are more easily expressed in attitude scales than in actual behavior because the scales focus on the existence of prejudice while such

prejudice may be a secondary factor in determining actual behavior toward members of the target group (Porter, 1971). In one study (Weitz, 1972), the amount of racial prejudice revealed on an attitude scale was negatively correlated with prejudicial behavior toward blacks. Those who acted in the most prejudicial manner showed the least amount or racial prejudice on an attitude scale. Thus, there is a compelling need to employ both scaling and behavioral measures in studying the development of age prejudice and to discover antecedent variables that contribute to its development.

Perceived role models of aging

There is evidence that the most compelling antecedent variables that correlate with negative attitudes toward the aged have to do with the absence of positive role models of aging. Maxwell and Silverman (1971) hypothesized that the principal factor governing the regard of old people in a society is the amount of useful information they are believed to possess. Cross-cultural studies have supported this hypothesis. In primitive societies, aged people are rare, so their experience and con tinued functions are accorded high esteem (Simmons, 1945). Cowgill (1968) also found that the status of old people is higher in cultures that are static, where the aged constitute a small percentage of the population, and where they have the opportunity to perform socially valued functions.

Studies have shown that where there are positive role models of aging, negative attitudes toward the elderly are less severe. According to Naus (1973), contact with the elderly and personal awareness of their abilities is related to others' attitudes toward them. Gordon (1970) found that older role models can and do influence the attitudes that younger people

have toward the aged as well as their own ideas about becoming old. Adults who lived in the same household with someone over 65 years had a more positive view of old people. Borges and Dutton (1976) reported that old people rated the quality of their lives more favorably than did college students who projected the quality of their lives at the same age. They suggested that such findings are a function of age segregation in our society. Young adults are not sufficiently aware of the rewards and satisfactions, abilities and accomplishments possible in old age. Rosencranz and McNevin (1969) found that college students who maintained close contacts with their own grandparents or other older people had more favorable attitudes toward the elderly than students who did not have such contacts.

If the quantity and quality of contact that people have with the elderly affects their attitudes toward this group, the vicarious experiences that people have in regard to the aged and aging through the media can also be expected to play a critical role in the formation of attitudes about the aged. In our society, the media, including books, songs, television programs, newspapers, etc., are principal sources of information /misinformation about what it is like being old. For the substantial proportion of people in our society who have no direct contact with the elderly, it is often the sole source of information. There are several studies that have shown that the elderly are not treated kindly nor accurately by the media; that negative stereotypes and low status role models prevail. Martel (1968) reported a significant decline in the status of older people in magazine fiction. Articles suggested that old people are past their prime and "out of it." The sparcity of positive role models of the elderly has also been noted in television programs. Aronoff (1974)

reported that only 4.9 per cent of the characters in prime time television are old. Furthermore, older people in television are associated with evil, failure and unhappiness. Northcott (1975) also reported that old people are very much under-represented by the television media. He found that only 1.5 per cent of all role portrayals were of old people. He also found that the roles of old people are peripheral to the major action of the plot and that old people usually serve as contrasts to competent males or attractive females in the script. The findings regarding the portrayal of old people in television are paralleled in children's literature. Old people are portrayed as lacking control over their own lives. The characters of elderly individuals are poorly developed and peripheral to the plot (Seltzer and Atchley, 1971; Peterson and Karnes, 1976).

In sum, the media tends to treat the elderly as peripheral and relatively unimportant. For those who do not have actual contact with older people and for the aged themselves who are often socially isolated, these media messages about aging are received without the opportunity to test their validity.

Attitudes of children toward aging and the aged

While research on the presence of negative social attitudes toward other target groups, particularly blacks, has shown that attitude formation is begun by the preschool years, there have been few studies of young children's attitudes toward the aged. Most of the studies of children's attitudes toward the aged have been limited to the adolescent period. It is not known when young children first begin to manifest negative attitudes toward the aged and how these attitudes are initially expressed in behavior.

The common stereotypes and misconceptions about the aged found among

adults are also prevalent among adolescents. Lorge, Tuckman, and Abrams (1954) found that junior and senior high school students perceived adolescence as a period of activity and the twenties as a period of establishment, goal orientation, movement and activity. People in their sixties and seventies, however, were viewed as being in a period characterized by inactivity, lack of interests and complete loss of adult roles. Kastenbaum and Durkee (1964) found that adolescents and young adults had a predominantly negative appraisal of old people. Old age was perceived as being risky, unpleasant and lacking significant positive values. Kastenbaum and Durkee concluded that the "now-orientation" of young people precludes an extention of themselves into old age and that the adoption of negative attitudes among adolescents may impair their own functioning when they enter old age.

Several studies have shown that the negative attitude that adolescents have of old people is susceptible to change. Labouvie-Vief and Baltes (1976) modified the perceptions that adolescent girls had of the elderly, making them more consistent with self-descriptions of elderly people. Adolescent girls were asked to simulate on a personality questionnaire the responses of a typical (but hypothetical) elderly woman before and after receiving discrepant feedback consisting of actual positive self-endorsements of elderly women. They found increased accuracy of perception among the subjects immediately after training and two weeks later. Others have suggested that increased contact between young and old people prior to adolescence would reduce long-range stereotyped perceptions of the aged (Lane, 1964; Bengtson, 1971; Ross and Freitag, 1976; Weinberger and Milham, 1975).

In one of the few studies of very young children's attitudes toward the aged (Hickey and Kalish, 1968), it was found that by eight years of age children have developed negative views of the aged. A questionnaire was administered to third graders, junior high school students, high school students and college undergraduates. The respondents perceived clear age differences between adults who were 25, 45, 65 and 85 years old and the older the adult, the less pleasant was the image held by children.

We can conclude, on the basis of this review of the literature, that to a significant extent the well-being of the elderly in our society is seriously impaired by the pervasiveness of negative societal attitudes towards aging. However, we know very little about the developmental origins of these attitudes and how amenable they are to positive modification.

Children's social attitude development

Generalizing from studies of the development of racial prejudice and sex-role stereotypes in young children, children's social attitudes begin to take shape during the preschool years and continue to develop through adolescence (Katz, 1976; Macgoby and Jacklin, 1974). There have also been several studies of the cognitive antecedents to young children's mature social concepts. For example, it has been shown that very young infants are capable of differential responses to cues about people (e.g., gender) even though they are not cognitively able to conceptualize different categories of people (Lewis, 1972). Children's earliest concepts of people are based primarily on cues having to do with gender, age, kinship, and race.

Referring to Piaget's (1969) position concerning children's concepts of aging, we can speculate that, until children are able to conceptualize the process of aging in a logically consistant manner, they would not be

able to systematically apply age-related stereotypes in formulating social judgments about the elderly. According to Piaget (1969), children's concepts about aging are based on two logical premises: the seriation of births and the conservation of age differences throughout life. The seriation of births entails the knowledge that older people (or any living organisms) were born before younger people, and that birth order instead of physical attributes is the basis of ensuing age differences. The conservation of age differences entails knowledge that aging is a continuous, irreversible process that never reaches a final state, even during adulthood when size differences between individuals are not longer correlated with age differences. Children, prior to the development of concrete operational structures (five to seven years), tend to confuse aging with changing in the physical features of people.

Piaget (1969) and Lovell and Slater (1960) assessed the development of children's concepts of aging by presenting a series of pictures of apple and pear trees which had different rates of growth. The trees were grown at one year intervals, growing larger and bearing more fruit. Although the apple tree was planted two years before the pear tree and was initially larger than the pear tree, the growth rate of the pear tree began to surpass that of the apple tree in both size and amount of fruit. By the ages of five to seven years, children had no difficulty seriating the pictures according to changes in each tree's respective size. However it was not until the ages of seven to nine that a majority of the children were able to correctly seriate pictures of both trees according to age independent of size.

Looft (1971) extended Piaget's age concept studies to human stimuli. Drawings of males and females representing four age levels (infant, child,

adolescent and adult) and two sizes at each age level were shown to children between three and nine years old. The ability to accurately judge the ages of the drawn figures independent of their contrasting sizes increased significantly with age. By age nine, more than three-fourths of the children made correct assessments.

Studies of children's ability to judge people's ages apart from the presentation of contradictory size cues have yielded equivocal findings. Thomas and Yamamoto (1975) found that, by nine years, children were able to accurately estimate the ages of young, middle-aged, and old people depicted in photographs. Britton and Britton, (1969) found that preschoolers were very poor on this kind of task, while Kogan and Wallach (1961) reported that preschoolers were able to make surprisingly accurate estimations.

It has been shown that, by three or four years, young children are capable of making many distinctions among people. Children at this age are particularly adept at distinguishing between gender and races, and these distinctions are already accompanied by positive and negative valences (e.g., Goodman, 1952; Stevenson and Stewart, 1958; Porter, 1971; Gaines, 1971). Katz (1976) has discussed some of the variables that influence the formation of racial attitudes. These include direct instruction, social reinforcement, personality factors, child rearing techniques, cognitive development, perception more influential than others in the acquisition of a particular social attitude. However, reviewers of research in this area (Katz, 1976; Pushkin and Veness, 1973) have complained that studies of attitude formation have focused on only a single variable at a time. They have argued that a better understanding of how social attitudes are formed will come from

studies that empirically consider a multiplicity of variables. They have also argued for the need for experimentally designed research to complement cross-sectional findings in this field.

Most of what is known about the development of social attitudes in children is based on their perceptions of gender and race differences. It is difficult to generalize from these studies to the development of children's attitudes toward aging because age discriminations are much more subtle (i.e., based on less perceptually salient cues) than race and gender discriminations. Unfortunately, there have been no studies to date of the origins and development of children's attitudes toward the aged; it is not known when they begin to acquire negative attitudes about aging and the aged nor how susceptible these attitudes are to positive social change. Given the primacy of early childhood experiences and attitudes in human development, efforts to change social attitudes in young children would be expected to have more far reaching effects than social policies aimed at older groups.

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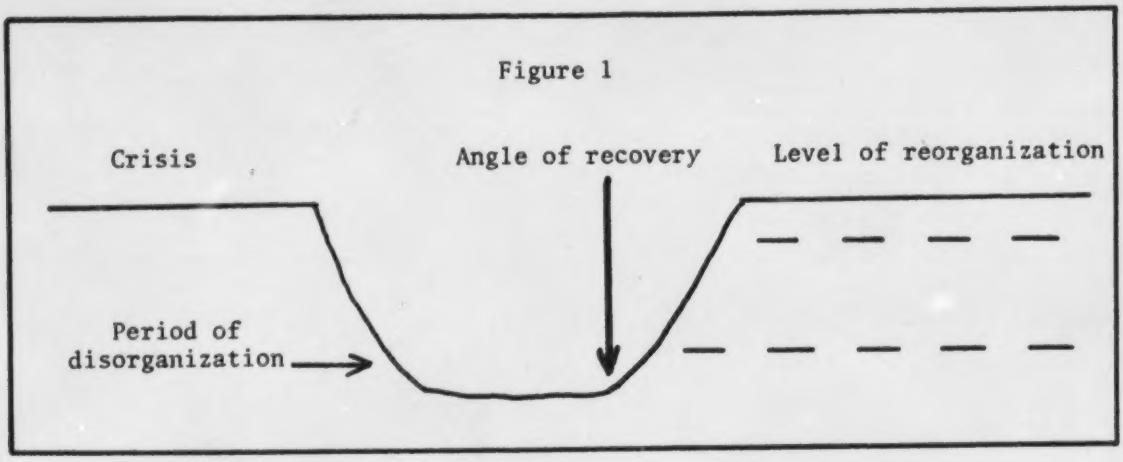
ILLNESS AND THE AGING FAMILY: A RECONSIDERATION

Edward J. Speedling

Much present writing on the effects of illness on family functioning has been influenced by Reuben Hill's 1958 well-known formulation that crisis in the family is typically followed by disorganization, recovery and, finally, reorganization. This process is depicted in Figure 1.

Figure 1



Two assumptions seem to underlie this way of thinking about the problem: First, the nature of illness is such that when it occurs, forces are set loose within the family which threaten to disrupt cohesion, cause disharmony, and usually do. Second, the nature of the family is such that it tends toward homeostasis, i.e., returning to a state which existed prior to the onset of the crisis.

The results of numerous empirical investigations appear to bear out these assumptions. Yet there have been occasional reports which indicate that sometimes illness can actually enhance family cohesion and improve

intra-familial relationships. One study (Jacobson and Eichorn, 1964) observed that the personality or characteristic behavior of husbands who had suffered heart attacks constituted the area of change that was most often reported by their wives and that some family members reported an improvement in the quality of family life as a consequence of the illness.

Croog and Levine's (1977) recent study of the social and psychological aspects of rehabilitation following heart attack focused on data collected at three points in time: during hospitalization, one month after hospital discharge, and at approximately one year after the onset of the heart attack. With regard to family adjustment, while there was no evidence that many families actually benefited in terms of an improved level of social functioning, neither was there evidence that families were socially crippled. The authors stated:

> Over the course of the study year, the general picture on the whole is one of apparent coping with the illness. Relatively minimal impact on family life is reported. . . . About 80 percent of patients reported that problems which had existed before their illness were not aggravated by it, and of the problems reported to be exacerbated by the illness, the majority were not family related (pp. 270-271).

Why is it that we have theories of how families break down following illness, but few, if any, theories of how families cope, overcome, and change when a member becomes ill? Is it because, as the bulk of literature seems to indicate, this is the reality of the situation? Or does it have something to do with how we think about illness and families? Perhaps the two are related, in the sense that the manner in which we view the problem affects what is done for families in illness crisis.

The use of the concept "system" to describe how families work may lead researchers to define their research problems in ways which obscure cases where illness in a family is a catalyst for change and creative response. System-related concepts such as homeostasis and re-equilibrium are meant to be used as tools to help explain highly-complex patterns of behavior in human groups such as families and are not meant to be taken as essential characteristics of the family unit. According to Hansen and Hill (1964), the family which emerges from a crisis strengthened has been ignored for this reason: "Viewing the family as a system should sensitize researchers . . . [however] . . . current conceptions of 'system' limit attention to concepts of 'reaction' and 'adjustment'" (P. 790). We can lose sight of the potential for human groups to change when research does not provide the medical and social service communities with the data upon which to develop aggressive, change-oriented programs for families faced with illness.

Another important contribution to current modes of thinking about social consequences of illness is the concept of social deviance. Under this formulation, illness, as a socially-devalued condition, is controlled by society's granting the sick person conditional legitimacy for his deviance, i.e., offering exemption from normal social role obligation on the condition that he recognize the illness as inherently undesirable and also recognize his obligation to seek technically competent help. This point of view, pioneered by Parsons (1951), and discussed repeatedly in the literature, would seem to call forth two behavioral modes of adaptation: withdrawal from social activity; and dependency on a physician. Variations in such role behavior by type of illness have been noted. Nevertheless, there are few alternate theoretical modes available to provide substantially

different ways of thinking about illness and social response to it. This has been noted by Segall (1976), in a recent review of the sick role concept as it has been used in the past twenty years. He states:

> In the case of chronic illness, the individual is faced with the necessity of adjusting to a permanent condition, rather than striving to overcome a temporary one . . . There is still no clearly developed social definition of the role of the permanently disabled or chronically ill . . . The tendency has been to treat [chronic illness] as an extention of the sick role, i.e., subtype (P. 164).

This, of course, focuses attention on the time-limited, socially-devalued aspects of the situation. Again, our theoretical frame does not offer meaningful ways of developing aggressive, change-oriented programs.

As individuals approach late middle age, they grow increasingly susceptible to illness. Especially significant for this discussion is chronic illness whose treatment often necessitates change in lifestyle. Data from 1972 (Social Security Bulletin, 1978) show that for persons aged 20-44 the prevalence of chronic conditions was 399.0 per 1000, while for those between the ages of 55-64 the rate was 662.8 per 1000 persons. Regardless of type of chronic condition, rates increase considerably with age. Older persons are also more likely to become disabled by their chronic illness. Disability, in turn, increases the risk for further illness. The relationship between age, disability, and illness in the prevalence rate of cardiovascular conditions among the disabled, which rose from 27.6 per 1000 persons under age 45 to 191.8 per 1000 persons aged 55-64. This is a sevenfold increase.

Less recent, but nonetheless relevant figures show that the percent of the population that is free from chronic illness declines

sharply and steadily throughout the life cycle until only 14.4% of the age group 65 years and over is free from any chronic condition. This illness experience accounts in large part for the fact that the average health bill for persons 65 and over is approximately six times that of individuals under 19, and about three times that of individuals between 19 and 64 (Mueller & Gibson, 1976).

This is clearly not a situation which evokes images of deviance. On the contrary, it would appear that an accurate characterization of illness in the aging population is that it is a normal and predictable event. As such, it ought to be able to be anticipated, and in some ways prepared for. Other age-related events, such as retirement and the "empty-nest" phenonenon, have the potential to cause personal and familial disruption. These occurrences are often experienced initially as crises, but the way in which we think about them is quite different from the way we have been accustomed to conceptualizing illness. These are events to be coped with through activity and are depicted as opportunities for the enrichment of the personality and family life. Retired, childless, even widowed persons are the recipients of important social supports. While we may not be satisfied with the level of public and private assistance they receive, the amount is considerable when compared to the lack of community services afforded, for example, the individual who has had a heart attack.

The major social consequence of chronic illness is the lifestyle change it requires in family and community roles. This is, in one sense, similar to other events, but illness -- even debilitating chronic illness -- is not seen, like retirement, as bringing about a new state of one's life, with new problems to be sure, but with new opportunities as well. In spite of the fact that illness is an event which has a high probability of occurring in

the above-fifty segment of the population, and in spite of the fact that this event has the potential of having very serious consequences for personal and family life, there exist virtually no social mechanisms for constructive anticipatory socialization. Since we have been content to ascribe to the person who is ill a passive role and a deviant status, there have emerged few, if any, constructive role models for individuals who face life changed through illness.

It is not my intention to argue that families which are stricken with, say, heart attack to one of the members, do not suffer considerably, and that the social and emotional sequelae are not difficult to cope with. One only has to observe family members as they hold vigil outside of the Coronary Care Unit, or speak with them and note the tension during the weeks after the patient returns home. There is no question that psychosocial problems rather than medical ones, are responsible for a significant amount of invalidism in former heart patients. But I do argue that with help, families can come through crisis, including the onset of chronic illness, strengthened, rather than weakened. To this end, research ought to be undertaken with the aim to understand the problems that can be anticipated at various stages of the illness process, and the means that families employ to cope with them. This kind of analysis, which is in serious short supply, is needed for programs aimed at <u>preventing</u> the social disruption which can follow in the wake of physical illness.

During a study of the way that family members coped following a heart attack to the husband-father, I interviewed people repeatedly about the changes they were experiencing. Many changes that were described were painful, and difficult to handle. Others, however, were perceived by some family members as bringing improvement into their lives. One kind of

positive life change which occurred was an increase in companionship. In one of the families studied, a major source of conflict between the spouses prior to the onset of the illness was the husband's numerous community activities, which the wife felt interfered with their marriage by depriving her of her husband's company. The fact that the illness was an impediment to much of this activity during the recovery phase was an advantage to this woman, who told me on one occasion, "Before I was always around. Now I have a companion. It's better for me . . . We talk back and forth. Normally I would be staring at the television with no one to talk to." For the husband's part, he seemed to "rediscover" the attractiveness of his wife as a companion. While at home recovering after hospitalization, this person began to look forward to his wife's company and experienced keen disappointment when she was late from work or went out alone with friends. This new pattern continued even as the man's recovery advanced to the point where he was able to resume activity at a near-normal level.

Another wife of a recovering heart attack victim told me that her husband had become more affectionate toward her than he had been previously. Her explanation for this change was that he was impressed and extremely grateful for her efforts on his behalf during the illness crisis. She told me that he made it known to her that "he owes his life to me". These examples of a heightened sense of togetherness and affection present a contrast to the "disengagement hypothesis", that with increasing age married couples tend to withdraw from one another emotionally, are less demonstrative and more separate. For some, illness can be an opportunity for special closeness, a time to draw together against a threatening event.

Another source of reward during illness may be enhanced self-esteem from the expanded role which the spouse normally undertakes following

illness. While the literature is well stocked with examples of the ways that the added tasks which healthy members assume following illness become burdens, there is relatively little discussion of the benefits which can accrue from assuming a larger share of familial responsibility. One benefit may be the chance to demonstrate competence to self and others through performance of important activities such as handling finances, managing the family's relations with other social groups, as well as taking responsibility for maintaining the continuity of the patient's medical regimen. One woman explained her situation prior to the illness this way: "I always felt my husband did many things that I could do that he wouldn't let me do, and I feel so stupid in so many things." While her husband was recuperating from his heart attack, this woman suddenly was thrust into a more expanded role, one which entailed decision making and required skill in judgment. The result was a remarkable change in her view of herself. She gained confidence and self-assurance in areas that were important to her. She actually enjoyed her expanded role in the home and planned to continue it even beyond the rehabilitation phase. Her success in accomplishing the dual roles of managing household affairs and coordinating the medical regimen was also reassuring to her husband during his incapacitation, and his gratitude reinforced his wife's emerging sense of self-worth.

The expanded roles which others play when one member of the family becomes ill and is thus unable to fulfill his normal role functions can relieve the sick person of burdensome activities. For example, the person who felt obliged to work an extra job because he felt insecure financially may see that in case of need his relatives will lend assistance, or that his child or spouse is capable of supplementing the family income. Thus, he comes to realize that he may safely shed the extra unwanted job.

Expanded roles may also bring additional power to some family members with which to influence the direction the couple or family will take through the period of rehabilitation and beyond. Power may accrue to well members by virtue of their having more opportunity to influence decisions and carry them out. Moreover, when one spouse is ill the other often assumes the role of medical surrogate, which gives the opinions and arguments of that person an added measure of authority. Decisions which formerly were made jointly and on the basis of accommodating all parties, now are made in light of the requirements of the medical regimen. And it is in this sphere which the well partner may exercise more power, and therefore more control, over family affairs.

The data which emerge out of my interviews suggest that a sphere which family members may frequently attempt to influence is one in which prior to the illness there had been important difference of opinion. Using leverage provided by the medical surrogate function, well members may attempt to re-define the contested issue as one which has a bearing on the person's health. As such, it would come under the purview of the expanded role of a well family member.

Changes such as those I have suggested may be permanent or temporary. They may be beneficial to all or some members of a family, to one or both spouses. They are rarely addressed in discussion either of coping with illness or of the aging family. Since we do not view illness as another point of transition in the life cycle of the family, we have no incentive to develop strategies to enhance the positive consequences of illness. We seem concerned with preventing personal and interpersonal deterioration, but not with personal and interpersonal development which comes from coping with and overcoming crisis.

Of particular concern for the aging family is the fact that illness may occur at a time of other major shifts, such as retirement. A man who has a heart attack in his early sixties may be forced to retire several years earlier than planned. Thus the illness may precipitate a natural lifestyle shift, requiring the family to confront issues which they would have had to face some time in the future. If the person recovers sufficiently to return to work, however, the group will have had, during the rehabilitation period, a foretaste of what retirement will be like. This experience can be used to prepare for the time when both spouses will be at home together, and roles, habits, and routines have to be adjusted.

Illness is a fact of life for most older people. In order to insure that couples can remain as independent as possible, it is vital to help them acquire the skills needed to manage their homes, including making the necessary role adjustments, during the acute and recovery stages of the illness. This means emphasizing change and development of new lifestyle possibilities, looking forward rather than backward.

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THE AMERICAN ORTHODOX JEWISH GRANDMOTHER: ETHNIC STABILITY AND ETHNIC CHANGE

Blanche Frank

Of the more than 20,000,000 Americans that are 65 years or more, 15.3 percent were born in countries other than the United States. (U. S. Bureau of the Census, 1973). The 1920's were the modal years in their immigration. Although many of these first-generation Americans have lived in America for a good part of their lives, the ethnicity they brought with them continues to affect their values, attitudes, and interpersonal relationships. This paper will examine one such American-ethnic generational cohort who came to America in the first quarter of the twentieth century and whose ethnicity continues to impact upon its life--the first-generation American[1] Jewish Orthodox.

In a larger generational study of Jewish Orthodoxy in America (Frank, 1975) several strands of American-ethnic culture were unraveled--the religio-cultural ethnicity brought from the Old World and the cultural traits acquired in the New World. Three generational families in America became the research model. More specifically, the first-generation American Orthodox Jewish housewife born in Eastern Europe,[2] her daughter's daughter --the third-generation American Orthodox Jewish housewife, became the focus of investigation. In this paper, however, we shall concentrate on the first-generation American Orthodox Jewish housewife--an extreme point in ethnic survival.

Despite the fact that this first-generation American woman has lived in America most of her life, she has tried to sustain many of the ethnic patterns that she had brought with her. Nevertheless she has accepted many

American ways. The insights we gain about her cultural resolution may shed light on the type of ethnic resolution made by others of her generation who attempt to sustain an ethnic commitment.

Background

The study population included 27 three-generational families located through the assistance of the National Council of Young Israel.[3] The subjects were the three-generational housewives related along the maternal line. Each was interviewed using a protocol that probed the following cultural elements:

Religiosity - components of Judaic ritual, knowledge, doctrine, emotion and homogeneous community involvement;[4]

East European - non-religious cultural items:[5] cuisine, Yiddish language arts and skills, patterns of educating children, traditional sex roles, relationships within the nuclear family, the extended family and mutual support, and marital choice;

American cultural items: cuisine, language arts and skills, attitudes regarding coeducational instruction, advanced secular education for both men and women, and extra-curricular activities for boys and girls.

In addition, life history data were gathered. Each generation has had its own experiences, and each generation has come to its own unique cultural resolution. The subject of this discussion is the cultural resolution of the first-generation American woman. In order to better understand this woman, we first turn to some essential demographic, social and economic characteristics.

The average of the first-generation American Orthodox Jewish women that fell into the sample was 76, with an age range from 63 to 87. The

places of birth for the respondents were Poland (10),[6] Hungary (7), Austria (6), and Russia (4). The average age at arrival was 18. Arrival in America was generally in the later years of the mass migration, with 13 arriving in the years 1920-1924, 9 arriving in the years 1910-1919, and 5 arriving in the years 1900-1909. Most first-generation women were raised in families with at least 4 siblings; the modal family group had 6 or more siblings. With respect to her formal education, both secular and sacred education were minimal; nineteen women had less than a grade school education and 14 women had no formal religious education. Although her father's occupation in Europe was an owner or manager of a business, the modal occupation of her husband was as likely to be a skilled or semi-skilled worker as an owner or manager of a business.

Table 1 summarizes the socio-economic and demographic characteristics of the first-generation woman in comparison to those of her second-generation American daughter and her third-generation American granddaughter. These characteristics put into perspective the life situation of the first-generation woman as it contrasts with the succeeding generations.

Table 1

General Characteristics of the Study Population

Characteristics	First Generation	Second Generation	Third Generation
Average Age of Respondent	76	49	26
Average Number of Siblings	5	3	2
Modal Occupation of Father While Respondent Was Growing-Up	Owner or Manager	Skilled Worker	Owner or Manager
Average Years of Secular Education	3	13	16
Average Years of Religious Education	1	5	12
Modal Occupation of Husband	Skilled Worker or Owner or Manager	Owner or Manager	Professional Semi-Prof. in Secular/ Sacred World

Ethnic Change and Ethnic Stability

Inquiring into the cultural strands of East European non-religious cultural items, the Judaic religious items, and the American cultural items revealed some interesting findings.

Acceptance of American ways. Despite the first generation woman's ethnic strength there is much in American culture that she accepts and that she has rejected in her East European heritage. For instance, the first-generation women felt that girls should attend yeshivot (in Europe, this was the boys' place); attending coeducational yeshivot is good (if girls did attend school in Europe, they were taught separately from the boys);

children should be encouraged to participate in sports and to enjoy rock music (in East European Jewish life this would have been considered frivolous and a waste of time better spent in learning); young married men should not be encouraged to continue their sacred learning and to receive parental support (it was considered an honor in East European life to have such a son-in-law); formal matrimonial introduction is not necessary (it was a breach of that tradition to do otherwise); parents and married children should not live together (in Europe the household often contained three generations).

Perpetuation of East European non-religious cultural ways. In the big picture, however, there is much about that East European way of life that she clearly has retained. Cuisine is an area of cultural life that seems to be particularly resistant to change. The first-generation woman has tried to remain within the East European tradition, preparing delicacies to bring to her children. Since the first-generation woman has had to consider the needs of low-cholesterol eating and other health problems, many East European dishes have become treats rather than mainstays in the diet.

Language is another area particularly resistant to cultural change. Although the first-generation woman has been in this country for at least fifty years, and her English is more than adequate, she still prefers speaking (27), reading (26), and writing (21) Yiddish.

Several cultural traits that are associated with the East European life, although not unique to it, were also explored in the interview. These items include the traditional sex roles, relationships within the nuclear family, the extended family and mutual support, family versus friends, and values associated with marital choice.

The first-generation woman has accepted the traditional roles of the woman and the man. The woman's place was undoubtedly in the home. Although some first-generation women recognized the necessity for a woman to augment the family's income by working, they surely did not recognize her need to involve herself in voluntary associations or organizational activity. Furthermore, first generation women were reluctant to permit their husbands to perform domestic tasks in the home. This was surely demeaning to the man and threatening to the woman's position as a domestic talent, a prized role. Although a few first-generation women had had educational and professional aspirations for their daughters (5), they more generally had had these aspirations for their sons alone (22).

The most sensitive question in this area, tapping the traditional role of women, was the question concerning the single Orthodox Jewish woman living away from home in her own household before she was married. The first-generation woman was visibly upset at this prospect. Some said it would be "a shame for the family", "not even a boy should do this".

The nuclear family has undergone change among the American Orthodox from the East European model. The first-generation woman respected and adored her mother as a 'queen.' She was devoted to her parents and did what she could to make them happy. Although most first-generation women would like to be treated in this manner by their children, such respect has not been forthcoming. One first-generation woman admitted that she would prefer her children to love her less and to respect her more. Some recognized that life was quite different in America, that parents and children were more open with each other, that people did not have to work as hard, and that there was much more fun and teasing in their relationships. Nevertheless, there seemed to be resentment in the lack of honor that was

accorded them in this stage of their lives.

The prospect of living with one's children, however, was rejected by the first-generation women who were not living with their children (15).[7] Although first-generation women had accepted the prospect of living together with their parents, they recognized the hardship that living together with children could cause. They did not in any way want to handicap or burden their children. Furthermore, many first-generation women realized how difficult it would be living with their grandchildren--"I can't take the noise", "my daughter does not discipline them enough", "they watch too much television".

Among the other Eastern European cultural items, the first-generation women were less concerned with friends than they were with family. The extended family, however, has diminished in size, with many contemporaries either dead or not religious enough for a close relationship.

Although most first-generation women abhorred the "shiddukh" or prearranged marriage, they preferred family background to romantic love in the choice of a mate.

A different religious commitment. Although the first-generation woman shares a religious commitment with her observant daughter and her observant granddaughter, it is qualitatively different kind of commitment, and it continues to show the stamp of its East European origins.

The first-generation woman is the most ritually observant. For instance her observance of Sabbath detail,[8] her past observance of mikveh,[9] the performance of the challah mitzvah, the covering of her head, the refraining from mixed dancing in her lifetime surpasses the observance of her daughter and her granddaughter.

Her daughter emphasizes another component of religiosity in her communal involvement. Whereas the first-generation woman stays within her

informal homogeneous primary groups, her second-generation daughter emphasizes a formal communal or organizational commitment. The second-generation woman is involved in synagogue affairs, yeshivah affairs and religious Zionist affairs to a degree that far exceeds the involvement of her mother and her daughter. Although the first-generation woman has had interest in burial societies and 'landesmann' groups that were formed when she first came to this country, interest in these groups has dwindled over the years. The first-generation woman recalled the demanding responsibilities she had at home which militated against communal involvement.

Her granddaughter emphasizes another component of religiosity. As a result of her many years of sacred education, she understands more and enjoys a spirit of inquiry when it comes to her religious heritage. In many ways the first-generation woman is placed at a disadvantage in America because knowledge and acculturation are needed in the practice of her religion. For instance, the practice of kashrut--the religious laws concerning food--demands a kind of conditioning that she had not fully received. With her lack of reading skills in English, she has found difficulty in keeping up with changes taking place in the field of kashrut. In purchasing food products various designations indicating kashrut supervision appear on many products. These symbols have to be understood and identified. Some symbols indicate reliable supervision; others do not. The first-generation woman seems to be uncertain as to what they mean, and consequently buys questionable products. She is often dependent on her children for this kind of information.

Perhaps the component in the first generation woman's religiosity that is most characteristic of her is 'doctrine' -- the strength of belief and the lack of doubt with which she goes about her religious life. When the

question was asked, "Are there times in your life when you wonder whether God really exists?" her response was more likely than not, "Never!" In fact, most were annoyed by the blasphemous idea. On the other hand, the second-and third-generations were less horrified by the question and fully discussed areas of doubt.

Thus, even within the religious tradition differences exist that separate the first-generation woman from her daughter and granddaughter. The first-generation woman is surely the most ritually-oriented and the most believing. This immigrant generation had brought a religiosity with it that is performed by rote and is reinforced by an unshakable faith.

Implications

Elements in the first-generation woman's cultural resolution display American cultural ways, East European non-religious cultural ways, and traditional religious ways. These cultural elements have had a variety of implications, and when these are examined consequences for their children, their homes, and themselves become apparent.

Adjustment to America. The way in which the first-generation woman adjusted to America evinces two patterns: on the one hand there was a conscious acceptance of American ways in preference to East European ways; on the other hand there was an easy acceptance of American ways without an appreciation for their consequences.

Apparently, there were elements in their East European lives that were objectionable to them. Among these ways were the lack of educational opportunities available for girls, forced matrimonial introduction, and the prestige accorded a young man who 'learned' (studied Torah) while he and his family were supported by his in-laws. Negative feelings toward such cultural elements were openly expressed by the first-generation. These woman certainly

preferred the educational opportunities America offered its girls, the more casual association between girls and boys, and the economic independence of young married couples.

On the other hand, their easy acceptance of other American ways seemed to indicate a lack of understanding of those ways. Although the first-generation women were anxious for their children to remain observant of the religion, they permitted their children latitude in their lives that succeeding generations would not have permitted. Many first-generation parents permitted their children activities on the Sabbath and the holidays that should have been prohibited. Many women explained that they wanted their children to be like other children in America. Even today many first-generation women are happy that their grandchildren participate actively in sports and enjoy the music of the day. In contrast, the second- and third-generation American women are much more discerning in what their children are doing. Although athletic activity is generally encouraged, these young Americanized women are much more hesitant about the music scene and the companions that music scene might attract.

Perhaps these patterns indicate that despite the first-generation woman's receptivity to many American ways, their acculturation is incomplete. Perhaps bona fide acculturation comes in the lives of the second and third-generations when there is an appreciation for consequences and ability to sort out the cultural ways.

Integrity of the home. There was one area in the first-generation American woman's life that was clearly her domain. In many places and at many times, she may have felt at a loss, but in her home she was in complete control. She could speak Yiddish, she could cook in her own style, and she could perform her religious ritual in just the way she chose with little

interference from the outside world. In her home, ethnicity survived in its purest form without the need to respond to a host of New World pressures.

The joint cultural patterns of the acceptance of American ways for their children and the ethnic environment in the home may have had far-reaching consequences--especially for the second-generation American children. Inadvertently, the immigrant parents may have been responsible for a dual environment that helped foster Americanization on one hand, but also perpetuated ethnicity, on the other. The second-generation children began life from this double-edged position--the home that epitomized the ethnicity and the outside world that elicited the parent's permissiveness. Although these children Americanized easily, there were sufficient ethnic elements--largely, the traditional religious elements--that were firmly implanted in their lives. When it came to their own children, the third-generation, the decisions they made[10] reflected a concern for the survival of the traditional religion. Of course, it was not exactly the East European Orthodox Judaism of the immigrant parents. It was instead a traditional Judaic survival cast in an American cultural form.

Ethnicity and a fragile old age. In many ways the first-generation woman finds herself in a disturbing life situation. In addition to the physical and emotional problems that are part of old age, she finds her ethnicity a compounding factor. Although she shares a Judaic commitment with her children, it is a commitment that emphasizes somewhat different components. Her family is all important to her, but their lives are filled with multitudinous activities, and she finds herself often left out. When she does relate to them, her expectations in the relationships are not always fulfilled. She knows how she respected her parents, but that type of respect is not forthcoming.

On the other hand, her children view her in another light. They see her as a dauntless bearer of tradition. Her second-generation daughter recognizes the pressure her mother withstood and the determination she showed in persisting in her religious convictions. Her third-generation granddaughter romanticizes her grandmother's background and regards with love and admiration her authenticity.

Unfortunately, this special admiration is not felt by the first-generation woman. The discrepancy between self-image and the image of her held by others signals the need for bolstering her ego. Her family surely recognizes the contribution she has made in their lives.

Conclusions

We have examined ethnic survival and its implications for elderly first-generation American Orthodox Jewish women specifically. What may we say about ethnicity and its survival for elderly first-generation Americans generally? There are several general conclusions that have been suggested:

- Americanization is incomplete for elderly first-generation Americans and may be superficial, especially in cultural areas that are far removed from their experience.
- Familial expectations in old age that have been conditioned by ethnic values may not be fulfilled in America.
- Attitudes and values among first-generation Americans regarding traditional masculine and feminine roles are particularly resistant to change.
- Although ethnicity may survive in later generations, it is an ethnicity that departs from the culture that is brought by the first-generation American.

- Ethnicity has had its firmest hold in the home which may have had far-reaching effects in ethnic survival among the children.

Although these conclusions may be strongly suggestive, they function as hypotheses that should be tested among the elderly in other first generation American ethnic groups. They should also be tested among the elderly in second-generation and third-generation American groups as comparisons to ascertain the degree to which the ethnic factor truly impacts in old age.

Notes

1
First-generation Americans are defined as those born in another country, but who emigrated to the United States at the age of ten or older.

2
Since traditional Judaism as encountered in American experience is principally known as a part of the cultural heritage of the descendants of the East European Jewish immigrant groups that came during the era of mass migration in the late nineteenth century and early twentieth century, Orthodox Jewish families were selected who reflected this cultural background. Hasidim are not included in our discussion because they are relatively new to the American scene.

3
The National Council of Young Israel is a movement that started in 1912 and includes approximately 100 Orthodox synagogues. Torah-true Judaism is its main feature, and its synagogues have a broad geographic distribution in the New York metropolitan area--the locus of this study.

4
These analytical elements of religiosity were drawn from Mervin F. Verbit, "The Components and Dimensions of Religious Behavior: Towards a Reconceptualization of Religiosity," in P. E. Hammond and B. John (Eds.), American Mosaic social patterns of religion in the United States. New York: Random House, 1970.

5
East European non-religious cultural items were drawn from Zborowski, M. and Herzog, E. Life is with people, New York: Schocken Books, 1952; Weizman, C. Trial and Error, New York: Harper and Brothers, 1949; Levin, S. Forward from Exile, Philadelphia: The Jewish Publication Society of America, 1967. Lawidowicz, L. The golden tradition: Jewish life and thought in Eastern Europe, New York: Holt, Rinehart and Winston, 1967; Ain, A. "Swiskocz: Portrait of a Jewish Community in Eastern Europe, Yiva annual of Jewish social science, 1949, 4, 86-114, and from discussions with Professor Florence Ruderman, a specialist in East European-Yiddish culture.

6
Numbers in parenthesis refer to the number of respondents to.

7
In the 12 cases where the first and second-generation live together, both generational members regard the living arrangement as satisfactory. In these families, the second-generation woman usually works and her mother does the cooking in the home and tends to domestic tasks. Some first-generation women did admit to friction over the way the grandchildren were being raised.

8
"Mikveh" refers to the ritual bath required for religious purification and prescribed for the monthly purification of married women. It is used by some men before the Sabbath and before holidays, and it is used for religious purification of new dishes and certain utensils. The act of actually taking the ritual bath is called "tevilah."

9
The challah mitzvah refers to the small portion of dough that is separated from the dough used in the baking of bread and burnt, accompanied by a benediction. It is one of the three commandments that women are obliged to perform. The other commandments are the observance of mikveh and the lighting of Sabbath candles.

10
A major decision made by second-generation parents was the sending of their children to yeshivot--the Jewish Day School where both sacred and secular learning take place. Not only did the yeshivah educate the third-generation in the ways of religious tradition, but the yeshivah provided homogeneous primary groups where attitudes and values of the religious group were supported and reinforced. In the parents involvement in yeshivah affairs, they, too, formed homogeneous primary group relationships. In a larger sense, a powerful 'plausibility structure' was formed. In Berger's (1969, p. 43) words:

> We obtain our notions about the world originally from other human beings, and these notions continue to be plausible to us in a very large measure because others continue to affirm them. It is, of course, possible to go against the social consensus that surrounds us, but these are powerful pressures (which manifest themselves as psychological pressures within our own consciousness) to conform to the views and beliefs of our fellow men. It is in conversation, in the broadest sense of the word, that we build up and keep going our view of the world. It follows that this view will depend upon the continuity and consistency of such conversation, and that it will change as we change conversation partners. Berger, P. L. A Rumor of Angels. New York: Doubleday, 1969.

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As a traditional Jewish homemaker and as a student of sociology for most of her life, BLANCHE FRANK was able to put the two interests together in a doctoral dissertation entitled, The American Orthodox Jewish Housewife: A Generational Study in Ethnic Survival. Since then Dr. Frank has had a keen interest in the larger phenomenon of ethnic survival in America.

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